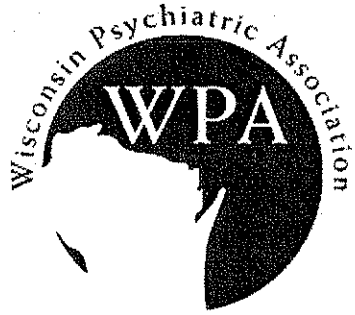

A District Branch of the
American Psychiatric Association

DATE: January 17, 2008

TO: Senator Jon Erpenbach and
Members of the Senate Health & Human Services Committee

FROM: Molli Rolli, M.D., Co-Chair
Wisconsin Psychiatric Association, Legislative Committee
Rachel Molander M.D.
Wisconsin Psychiatric Association

RE: Support of Senate Bill 375

Molli Rolli M.D. Associate Professor, University of Wisconsin, Madison. Co-Director, Inpatient Psychiatry, University of Wisconsin Hospitals and Clinics, Co-Chair, Wisconsin Psychiatric Association Legislative Committee. Chair, Council on Ethics, Wisconsin Medical Society.

Rachel Molander M.D., Resident Physician, University of Wisconsin, Madison, Department of Psychiatry.

This testimony is presented on behalf of our patients, ourselves, the Wisconsin Psychiatric Association which represents 500 Psychiatric Physicians throughout Wisconsin and the Wisconsin Medical Society.

We, like the colleagues we are representing are Physicians who treat patients with serious mental illness. Psychiatrists practice in many settings including hospital-based services, nursing facilities, community-based clinics and programs, along with all the health programs under the auspices of the state government, such as county mental health services, community support programs and state hospitals. Psychiatric physicians also provide service and leadership as academic faculty and practitioners and academic medical centers of excellence and are at the forefront of research on the sources of new treatments for persons with mental illness, including substance use disorders.

First and foremost, we wish to thank Senator Hansen for his ongoing leadership on this issue and we wish to thank you, Senator Erpenbach and Members of the Committee, for your willingness to hold a public hearing on this vital topic.

We have chosen to refrain from making a moral argument about mental health parity. We believe there is a valid moral argument but we have chosen to focus instead on two issues. The first is that mental health parity is good for business. The second is that Mental Health Parity will keep more people working in Wisconsin. Of course, if you wish to hear the moral argument we will be happy to oblige you.

Mental Health Parity is Good Business

Nationwide business is acknowledging the cost of mental illness in the workplace. Employee Benefit News, a leading publication for HR professionals, and the Partnership for Workplace Mental Health, recently released the results of a national survey in which HR professionals from across the country selected mental illness as the health issue that has the most effect on indirect costs to businesses.

The American Psychiatric Foundation's Partnership for Workplace Mental Health program has developed an extensive body of research on the impact of inadequate mental health treatment on productivity and the bottom line for businesses.

More important to this debate in Wisconsin is the contention by some business advocates that increasing mental health benefits would increase costs to business. Given that we are one of only a few states to not have mental health parity, there is a body of research developing that shows no real cost to business when mental health parity is paired with utilization review.

Utilization review is the process insurance companies use to determine if they will agree to pay for a medical expense. Utilization review is the tool insurance companies use to avoid paying for unnecessary medical costs. Increasing the benefit does not give treatment to people who do not need treatment. When benefits increase utilization review insures that only those people in need of treatment get it. For example, hospitalization is generally not approved unless there is actual danger in releasing the patient from the hospital. Now, when a person's benefit has been exhausted the insurance company does not have to pay no matter how dire the situation is. Examples of patients who need to be in the hospital include suicidal patients and patients who are hearing voices telling them to harm other people. When the benefit is gone the payment of the expenses of these people in one way or another goes to the taxpayer.

An excellent example of a study of the cost difference appeared in the New England Journal of Medicine in 2006. It was entitled, "Behavioral Health Insurance Parity for Federal Employees". It concluded that when mental health parity is coupled with utilization review service improves without increasing total costs.

Parity Would Keep More People Working in Wisconsin

When the private sector does not provide adequate mental health benefits the burden of caring for people with serious mental illness is shifted to the public sector.

In our practices we see many people who are on disability who could work if they could get adequate mental health coverage. When a working Wisconsin citizen is stricken with a serious mental illness that requires hospitalization, their insurance policy is allowed to cover only about 4 days of inpatient hospital care in any calendar year. This is not adequate time to treat the most serious mental illnesses. It is very often in that patient's best interest to discontinue their insurance (quit their job) and apply for

disability because Medicare provides superior coverage. We have seen this situation occur countless times.

The lack of mental health parity does not affect the poor. Medicare and Medicaid are superior forms of coverage for mental health issues. Working people are left with no option when they or a family member develops a serious mental health problem than to apply for disability. Few families are wealthy enough to afford the out of pocket expenses required to treat a serious illness. In effect we end up "throwing in the towel" on a return to gainful employment before we have had a chance to treat the illness. Once a person gets disability their chance of returning to gainful employment is very small. It is common for our patients who could return to work, to avoid getting work because they would no longer be able to afford the treatment they need when they switch from Medicare or Medicaid to private insurance.

While the parity law won't remove every barrier to mental health, it will be a step forward and the Wisconsin Psychiatric Association hopes that this legislature will move this important legislation through both houses and pass legislation this session. Thank you in advance for your consideration. We will be happy to answer any questions you may have.

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126 South Franklin Street • Madison, Wisconsin 53703 • Phone 608-251-1450 • Fax 608-251-5480 • Email wispsych@execpc.com • Web www.wipsychology.org

TESTIMONY
SB 375
Senate Committee on Health, Human Services, Insurance, and Job Creation
January 17, 2008

Senator Erpenbach and members of the Committee:

My name is Sarah Bowen. As Executive Director of the Wisconsin Psychological Association and as one of the co-chairs of the Coalition for Fairness in Mental Health and Substance Abuse Insurance, I welcome the opportunity to speak today in support of Senate Bill 375.

My testimony will focus on one point: it costs the state of Wisconsin and its businesses and its healthcare system more when we do not to provide parity in mental health and substance abuse coverage than when we do.

Healthcare economists employ a concept called "the burden of disease" to describe the impact of various disorders on individuals, on the healthcare system, on business and on society. They remind us that there are often even more substantial indirect costs associated with an illness than there are direct costs. The Global Burden of Disease Study conducted by the World Health Organization, the World Bank and Harvard University shows that mental illness ranks second in the burden of disease in our economy.

Approximately 90% of individuals with substance use disorders work. At least 72% of individuals with mental illness work. Using the approach of the healthcare economists, we need to measure cost in a larger context that goes beyond insurance premiums and takes into account such indirect work-related factors as short- and long-term disability, absenteeism, and productivity.

There are many studies supporting the assertion that behavioral health disorders cost our society a lot of money. The Surgeon General reported direct treatment costs for mental illness of $69 billion and indirect costs of $79 billion for 1990. In economic terms, that's a really long time ago. Today, that $79 billion figure would translate to more than $123 billion. While the specific estimates may vary, it is clear that a major portion of the indirect cost is attributed to lost productivity.

Consistently, both economic and healthcare research document that the most commonly treated — and untreated — mental health disorder is depression. Roughly 1/3 of the cost of this disorder is for treatment, and more than 2/3 of the cost is related to absenteeism and lost productivity at work.

A 1999 study documented declines in absenteeism for employees treated for depression. Similar reductions in absenteeism, poor job performance and personnel conflicts were demonstrated following treatment for substance abuse disorders.

- A Connecticut company reduced its mental health services to save money — but what they found was that their general healthcare costs increased, use of sick leave increased, and productivity decreased.
- General Motors estimates it saves $37 million per year by providing Employee Assistance Programs for their workers
- United Airlines estimates nearly $17 return for every dollar spent
- Northrop Corporation reports $20,000 savings per employee who is successfully treated.

The National Business Group on Health has estimated that 181 million workdays are affected by reduced productivity due to mental illness. More than 1.3 billion work days are lost each year due to mental disorders, roughly half the number associated with all chronic physical conditions combined. One study noted that short-term disability claims translate to 18-27.6 days per year. Employers are paying in disability payouts, productivity loss and expenses associated with covering for the absent employee.

In Wisconsin, an estimated 2.08% of commercial insurance claims were filed for major depression, translating to about 17, 300 citizens who sought treatment for depression, and accounting for over 170,500 missed days of work in one year. These numbers are even more significant when we include the fact that they do not include those people who may have depression but have not filed an insurance claim for treatment.

Businesses are paying for mental health and substance abuse disorders whether or not their health plan provides parity. Wisconsin businesses are carrying a heavier indirect burden for these disorders than they would if insurance parity were enacted in our state. Businesses in states that have comprehensive parity laws have expressed satisfaction with these benefits. As one CEO expressed it: "providing mental health benefits on par with physical health benefits is good for the bottom line."

Thank you for the opportunity to appear before you today. I will be happy to answer any questions you may have and to provide any follow-up information you would find helpful.

TESTIMONY BY NASW WI EXECUTIVE DIRECTOR MARC HERSTAND ON SENATE BILL 375 TO THE SENATE COMMITTEE ON HEALTH, HUMAN SERVICES, INSURANCE AND JOB CREATION ON JANUARY 17, 2008

Chairperson Erpenbach and members of the Senate Committee on Health. Thank you for this opportunity to present testimony on Senate bill 375, the mental health/substance abuse parity bill.

My name is Marc Herstand. I have served as the Executive Director of the National Association of Social Workers, Wisconsin Chapter for over 15 years. NASW WI represents over 2300 social workers throughout the state of Wisconsin who work in hospitals, outpatient mental health clinics, county human service departments, nursing homes, community based organizations, school districts, colleges and universities, state government, business and other settings.

In addition to representing NASW WI, I am also one of several speakers today representing the Fairness Coalition for Mental Health & Substance Abuse Insurance.

The Fairness Coalition has been working to get a mental health and substance abuse parity bill passed for close to ten years. Over the years we have presented information about the need for full coverage, and the terrible hardship on families who lack this coverage. We have provided information about the health care costs and costs to businesses of untreated mental illness and substance abuse.

One of the persistent arguments against mental health/substance abuse parity has been the concern that increasing the amount of coverage from the current minimum mandate would increase costs to businesses in Wisconsin.

While in the past we did not have a lot of research addressing the cost issue, that is not true today. In my comments today I would like to briefly present some of the most recent research on the cost issue.

First since 1999 federal employees have had full mental health and substance abuse parity. In 2006 the New England Journal of Medicine published a study entitled, "Behavioral Health Insurance Parity for Federal Employees" that compared Federal Employee Health Benefit plans over a three year period with other health plans that do not have mental health and substance abuse parity. The conclusion of this very detailed study was that when coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs.

Secondly, again in 2006, the journal Health Affairs published an article entitled, "The Costs of Mental Health Parity: Still an Impediment". This article examined authoritative studies of the

effects of mental health care benefit changes. What the study found was that the relevant research implies that parity implemented in the context of managed care would have little impact on mental health spending and would increase risk protection. One of the studies examined in the article was from the Congressional Budget Office which estimated that comprehensive parity would raise premiums between .4 and .9 %.

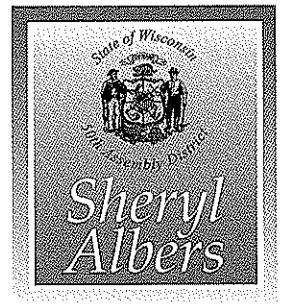
In addition to these studies of federal employees and other health plans, there have been a number of studies of the impact of the implementation of mental health and substance abuse parity from specific states.

The National Conference of State Legislatures reported in 2002 that in the State of Minnesota, which has had parity since 1995, cost rose just 26 cents per member. The U.S. Department of Health and Human Services reported that in Vermont, which has had comprehensive parity since 1999,one major insurer reported that cost increased 19 cents per member after parity, while another insurer reported costs had decreased. In 2004 Price Watterhouse Coopers conducted an actuarial analysis of comprehensive mental health parity for the State of Washington and found that the expected Net Insurance Impact for health costs will rise about 0.44 % or $1.17 per member per month.

I would be happy to share complete copies of the studies I have referenced in my testimony.

In conclusion while some groups and legislators might have philosophical reasons to oppose mental health/substance abuse parity, as I hope I have demonstrated in my testimony, opposition to mental health and substance abuse parity on the basis of increased total spending is no longer supported by any research or evidence.

Please pass SB 375.



State Representative Albers Testimony on SB 375 to
The Senate Committee on Health, Human Services, Insurance,
& Job Creation – January 17, 2008

Thank you Chairman Erpenbach and members for your consideration today of Senate Bill 375, the Mental Health Fairness Act. This legislation has been introduced in some form over the last ten years, and in that time as lawmakers we have heard personal stories of how mental illness has impacted an individual or family in heart-wrenching ways, about discrimination in insurance coverage, advancements in diagnosing and treating mental illnesses, and whether or not equal coverage of mental illnesses will result in higher costs for other consumers and businesses in the insurance market. Today, however, I want to focus on how passage of SB 375 can also improve worker productivity and Wisconsin's business climate.

SB 375 requires all insurers to provide coverage for mental health services, equal to that provided for physical health care.

Ensuring equal treatment of both types of health care makes sense for Wisconsin's economy:

- Various studies have shown that U.S. businesses lose between $79 and $105 billion per year due to inadequately treated mental illnesses.

State Capitol Office: P.O. Box 8952 • Madison, Wisconsin 53708-8952
(608) 266-8531 • (877) 947-0050 • FAX: (608) 282-3650 • Rep.Albers@legis.wi.gov
District: 339 Golf Course Road • Reedsburg, Wisconsin 53959 • (608) 524-0022

- 36 million productive workdays are lost every year in the U.S. due to behavioral health disorders, costing employers an estimated $5 billion annually.
- In fact, the National Committee for Quality Assurance estimated that nationally there were 8.4 million sick and lost productivity days among workers with depression alone, amounting to almost $1.4 billion in lost productivity. In Wisconsin, the number of work days lost to depression alone is 170,000 days/yr. More days are lost when other mental health disorders are added to the mix.
- Wisconsin employers lose roughly 226,000 days per year in reduced worker productivity due to depression-related illness.
- Research also suggests that workers with inadequate coverage who have a mental illness or substance abuse often rely upon short-term disability benefits.
- Studies show that workers not undergoing treatment for a mental health disorder are more likely to be indecisive, make poor judgments, and lack self-confidence, which frequently results in accidents in the workplace, and increased draws on unemployment compensation or workers comp accounts.

Comparable treatment of mental health services can reverse these sobering numbers, benefiting employers and employees, without significant cost to insured/payers. If enacted, Wisconsin businesses would save millions of

dollars every year in recovered work days, worker productivity, reduced number of disability claims and lowered training and recruitment costs. Our business climate here would improve as Wisconsin would join the 41 other states which have already enacted mental health parity legislation, giving business owners another reason to consider Wisconsin's workforce when contemplating startups or expansions.

It is expected that Wisconsin's federal UC account will fall into negative balance if UC criteria are not modified this session. Not all states which have had mental health parity in place for several years face like circumstances as to their UC accounts. There may be a direct correlation, and there are several studies which suggest Wisconsin's UC account would experience less draws if a mental health parity law were enacted here.

This bill has been misrepresented by many as simply another unfunded health mandate. Studies of states which have already enacted mental health parity show that full coverage of mental illness and substance abuse results in significant health care savings throughout the insurance market within the first three to five years. Some states with sound managed care systems experienced net savings within the first two years of implementation. Proper treatment of mental illness has been found to reduce the number of claims for physical health services, ultimately resulting in lower premiums or slower premium growth for all persons in the insurance pool.

In closing, I would invite committee members who disagree with the proposal before them to look at parity laws in other states and work with us on a solution that does not leave consumers, businesses and taxpayers behind here in Wisconsin.

Testimony to the Committee on Health, Human Services, Insurance, and Job Creation
Wisconsin State Senate

Regarding

Mental Health and Addiction Parity
Senate Bill 375

Presented by
Michael M. Miller, MD, FASAM, FAPA
Medical Director, NewStart Alcohol/Drug Treatment Program
Meriter Hospital, Madison, WI

Associate Clinical Professor
Departments of Family Medicine, Psychiatry, and Internal Medicine
University of Wisconsin School of Medicine and Public Health

Past President, Wisconsin Society of Addiction Medicine
Current President, American Society of Addiction Medicine

Past President, Dane County Medical Society

Recent Board Member
Wisconsin Medical Society and Wisconsin Alcohol and Drug Treatment Providers Association

January 17, 2008

Chairman Erpenbach and Distinguished Members of the Committee:

Ladies and gentleman, thank you very much for allowing me to share some information with you relevant to the legislation before you today. And I am pleased to report to you that my own employer, Meriter Health Services of Madison, one of Wisconsin's largest employers, now supports parity for mental health and addiction benefits, so I am testifying today on behalf of Meriter as well.

I practice medicine full time at Meriter Hospital in Madison. My specialty is addiction medicine. I am also board certified in general psychiatry and addiction psychiatry. I've practiced these specialties in Wisconsin for almost 25 years. I am on-call today at the hospital and I am most appreciative of you, Chairman Erpenbach, accommodating me today. I'm proud to be a constituent in your district.

In the progressive Wisconsin tradition, Wisconsin at one time was a pioneer and trendsetter in mental health insurance reform. Thirty years ago, when many insurance plans included no coverage for psychiatric or AODA care, Wisconsin's mandated benefits law required private

insurers to include at least $6300 of coverage per year for these conditions. Now, virtually no public or private employee in America has an insurance plan that contains no mental health or addiction benefits at all. And now, Wisconsin is behind the times. Federal employees have full parity for addiction and psychiatric care in the FEHBP. State employees in North Carolina and many states have full parity. Citizens in Vermont have full parity. Over 35 states have some degree of parity mandated by law into private health insurance benefits. Wisconsin does not. It is time to bring Wisconsin employees up to par, as Senate Bill 375 would do.

I have presented testimony before the legislature for several years on these topics because mental health and addiction parity legislation has been before legislature many times before. The usual approach has been for me to speak as a practicing physician and as Chair of the public policy Committee of the American Society of Addiction Medicine, talking about the patients I treat, addressing how addiction is a brain disease, addressing the health impacts of substance use and addiction, and how irrational and unfair it is that health insurance pays for treatment for some brain diseases such as Parkinson's disease and epilepsy in the same way that is pays for heart disease and cancer, but it pays for the treatment of other brain diseases such as manic depressive illness and alcohol addiction, in a very discriminatory way. I am not here today to discuss issues of fairness and biology. But I am here to share with you some thoughts on why it's important for Wisconsin business to pass mental health and addiction parity legislation.

First, is parity affordable? I have testified previously before the Legislature about how there is EVIDENCE from parity implementation in other states, about what it will cost to include full parity for mental health and addiction benefits. In previous years, I warned you to listen for testimony from so-called 'business interests' who would provide inaccurate numbers on how much premiums would rise if Wisconsin were to adopt parity. The facts are, from observing parity in other states, that parity for MH benefits increases premiums 0.3-0.7%, and parity for AODA benefits raises premiums even less, only 0.1-0.2%. We can expect that Senate Bill 375 would raise health insurance costs 0.4-0.9%. This is a small price to pay for equality.

Addressing the health problems of addiction to alcohol and other drugs, and the health problems caused by substance use and addiction, is very relevant to the business community, because over 60% of Americans and Wisconsinites with drug addiction are employed, and about 80% of problem drinkers are employed. These individuals are in the workforce and are covered by employer based health insurance plans. You all know the contribution of health insurance as an employee benefit that affects the bottom line of Wisconsin employers.

The historical response to alcohol use in the workplace was to dismiss employees who caused workplace accidents while under the influence while on duty; to eliminate from consideration potential employees who had positive pre-employment urine drug tests; to dismiss employees who had repeated positive urine drug tests; and to otherwise ignore alcohol and drug use among workers – sometimes assuming that alcoholism wasn't a significant issue for the employees of MY company, or considering even alcoholic patterns of drinking outside the workplace to be a private matter and an aspect of the employee's personal life but not his or her work life.

Some well-publicized alternative approaches included having HR policies that prohibited tobacco smoking for any employees, even during off-work hours, considering the burden of

health care costs generated by the employee to be too great to bear – so refusing to recruit or retain employees who were addicted to tobacco.

The most enlightened employers now know that addiction to alcohol and other drugs is very relevant to the health of the company and not just the health of employees or dependents. Employees impacted by, and distracted by, addiction in themselves or in a life partner, a child, or a parent, are unable to do their best for their employer, and contribute to workplace errors (in both white collar and blue collar occupations) as well as workplace absenteeism, tardiness, and injuries. The term PRESENTEEISM has come to be used along with the term ABSENTEEISM to capture the problems in workforce productivity by workers who are under the influence, 43 recovering from being under the influence, preoccupied during work with obtaining drugs after work, preoccupied with a loved ones addiction – or even spending work hours surfing the Internet to locate on-line supplies of pain killers or tranquilizers.

The latest estimate of the costs of alcohol problems in the United States are close to $200 billion/year. While more than $50 billion is due to excess healthcare costs, vehicular crashes, property loss, and crime, the cost to business of untreated addiction to alcohol alone is almost $150 billion/year associated with lowered productivity due to absenteeism, presenteeism, disability and job turnover. Please note that of the healthcare dollars spent by employers in the US on addiction, well under 5% is spent on addiction treatment itself, while over 95% is spent on treating the medical/surgical and psychiatric complications – the injuries and illnesses caused by substance use and addiction.

Employers now know that retaining skilled workers is far less expensive than dismissing them and recruiting and training new ones. Rehabilitation of an employee with addiction makes more business sense than dismissing the employee. Employee Assistance Programs are designed to provide early identification of cases of mental health and substance use disorders, and to provide intervention and referral services to employees with mental health and substance use problems – and to get patients treated through effective treatment services so they can return to work more functional than ever.

Data is clear that healthcare utilization for addicted employees is much lower after an episode of addiction treatment versus prior to the addiction treatment episode – and often, prior to the addiction treatment episode, the employer and the front line supervisor were unaware of the person's addictive disease. The supervisor may be aware of performance or attendance issues. The Chief Financial Officer maybe aware of the employee's healthcare utilization data. But without identification of the AODA problem, the linkages between an addictive disease and suboptimum financial performance for the employer would not be appreciated.

In 2006, over 60% of full-time employees aged 18 or older drank alcohol. Among 16 million risky drinkers in America, almost 13 million were employed. Low and high risk alcohol users cover a larger percentage of the drinking population than people who are actually addicted to alcohol. Yet, these moderate drinkers caused 60% of alcohol related absenteeism, tardiness, and poor work quality. In addition, reports estimate that up to 40% of industrial fatalities and 47% of industrial injuries are linked to alcohol use. Misuse of alcohol is linked to almost 50% of all

trauma and injury-related emergency room visits, which tends to increase employers' health insurance expenditures and drive up the costs of insurance premiums.

When large and small employers, alike, help their employees address alcohol problems by offering appropriate services that include screening and brief intervention, they are likely to experience lower healthcare cost growth rates, and a return on investment of at least 2.1% (Eric Gopelrud, PhD, Ensuring Solutions, George Washington University).

Employers have traditionally looked at the costs of mental health and addiction treatment, and seen them as "cost-added" for the employer. But especially in the case of addiction care, addiction treatment is clearly value-added. The current question for employers who understand the data is, how can an employer afford NOT TO TREAT addiction in his/her employees?

Recall that the healthcare costs associated with substance use and addiction are greater than 95% due to the cost of treating the complications of substance use and addiction – addiction treatment costs are less than 5%. Only $8 billion dollars/year is currently spent on treatment of addiction out of the $2 trillion dollars spent on health care services on our nation, because only a fraction of persons with addiction who need treatment, receive treatment. In the health services research literature, this is referred to as the "treatment gap." America and Wisconsin cannot afford to sustain this treatment gap. This is why the federal Healthy People 2010 Report, and the State of Wisconsin Department of Health and Social Services Healthiest Wisconsin 2010 Health Plan, both have specific sections devoted to narrowing the treatment gap for addiction.

One reason for the treatment gap is a lack of health insurance coverage for addiction treatment. Please be aware that the value of private health insurance benefits for addiction treatment have lost over 75% of their value in the last 25 years. The Wisconsin mandated benefit of $6,300 dollars a year total, for mental health and addiction costs, has not risen in the 30 years since the hallmark legislation was passed mandating psychiatric and AODA care. Employees in Wisconsin who have excellent insurance for their general health care needs are virtually all under-insured for mental health and addiction care. Note also that in our current economic environment, the private sector has basically abandoned persons with addiction. Of all of the dollars spent on addiction treatment in our nation, 76% are paid for by the public sector. Only 9% of treatment costs are bourne by private insurance payments. This involves a tremendous cost shift from the private sector to the public sector – which means, to the tax payer. The public sector pays for a much larger percentage of addiction treatment than it does cancer treatment or diabetes treatment. Without parity of the kind that would be created by the legislation before you today, commercial insurers believe that there will be adverse selection of policies that have more generous coverage for mental health and addiction. Employers face the same dilemma – no one wants to be the first to offer more generous benefits and put themselves at a perceived economic disadvantage. We need to have a level playing field. Employers are motivated by such arguments despite the reality that parity for addiction care saves $7 for every dollar spent, based on numerous studies from various parts of the country.

Yesterday I was in Washington, DC, for a White House sponsored conference on screening and brief intervention for alcohol problems, and the data presented there is that the cost benefit

analysis shows that for every dollar spent on screening and brief intervention in the workplace or in health care settings, $4 is saved. So this really is value-added service.

I would like to share with you some data I received at the conference yesterday in our Nation's Capitol, presented by the Director of the National Institute on Alcohol Abuse and Alcoholism. His data shows what a huge contributor mental health and addiction problems are to disability in our nation. The statistic used is called Disability Adjusted Life Years, or DALY. Of the ten leading causes of DALY's in the United States, heart disease and stroke were number one and two, but depression was number four, alcohol was number seven, and motor vehicle crashes were number three – and we know how many auto crashes are attributable to alcohol. Of the actual causes of death in the United States, number one is tobacco – (this is an addiction). Number two is poor diet and physical activity leading to obesity. And number three is alcohol consumption. We are not talking about rare or irrelevant health conditions – we're talking about the "horses" here, not the "zebras." If we want to reduce overall healthcare costs we must give people ready access to treatment for alcohol problems, because of the contribution of drinking to health outcomes for a wide range of health care conditions, including cancers, high blood pressure, stroke, as well as cirrhosis of the liver. Why give people access to full insurance coverage for high blood pressure and tell them to watch their diets, and deny them access to alcoholism care, when the data show that a person's alcohol use contributes just as much risk to their blood pressure as does their salt intake! (PRISM Project, A.T. McLellan, PhD, University of Pennsylvania)

Parity is also wise in this way: a patient with diabetes and depression costs twice as much to treat on average as a diabetic who is not depressed. Untreated psychiatric and addiction problems make it more expensive to treat almost any chronic medical problem, driving up employer costs. The best way to save employer dollars on health care costs is to pass Senate Bill 375 and remove barriers to access to effective treatment of psychiatric and substance related disorders, so the care of chronic diseases by internists and family physicians can generate optimum results most efficiently.

At this National Leadership Conference I attended this week sponsored by the White House Office on National Drug Control Policy, we were given an article hot off the presses from the American Journal of Preventive Medicine. What this shows is that screening and counseling regarding alcohol use is just as important a preventive intervention as more commonly known interventions. Among 25 preventive interventions studied by the US Preventive Services Task Force, alcohol misuse got a score that was similar to screening for colorectal cancer, hypertension, and influenza immunization. In other data presented at this Conference, the most effective prevention intervention is to have people stop smoking. The second is to provide aspirin for a heart attack patient. Number three of all prevention interventions as far as effectiveness, is screening and brief intervention for alcohol problems. It's more effective, in some studies, than colorectal cancer screening and vaccinations for pneumonia and influenza, and even more effective than pap smears, mammograms, and prostate cancer screening. Anyone screening "positive" should be referred to treatment. With parity, treatment will be affordable and available.

Given this compelling data, we cannot afford to have barriers to access to care for alcoholism. We cannot afford to continue the status quo, without parity, where patients can't get their alcoholism treated in ways that will save them and their family untold pain, and their employer significant real dollars.

How has American business, and Wisconsin business, dealt with alcoholism and drug addiction treatment historically? Employees with a child who has cocaine, heroin, Vicodin, marijuana, or alcohol addiction or anorexia nervosa, will call their family doctor – and their doctor will say, "I don't know where there are services I could refer you to." They contact their Employee Assistance Program, who gives them a name a treatment center. They call HR and check their benefits. And they see that for cancer, heart disease, diabetes, and other brain diseases, there are full benefits, but for alcohol and other drug addiction, another disease of the brain, there are very limited benefits. Wisconsin mandated benefits will pay for three days of hospital costs, or 10-15 days of residential treatment costs, or 30 days of intensive outpatient treatment costs – with no dollars left at all for the ongoing care that we know is needed after primary treatment to keep this chronic illness in remission. So, if someone in the family needs residential treatment, the employee is left to self-pay for it basically – with the money required presenting them a significant financial burden.

What happens if CEO has a family member with the same problem? They realize that their health insurance wont pay for it so they just dip into their savings account and self-pay for care, even at more expensive programs such as the Betty Ford Center or other out-of-state programs. So what happens today – the CEO gets care, and the front line employee doesn't get care because of financial barriers. Is this fair? The parity legislation before you will address this.

So I don't have a degree in business or economics – I'm just a practicing physician here in Madison. But I care about these topics because they affect the real lives of real people in my practice every single day and they affect the economic health of businesses in Wisconsin.

To reiterate, please recall, the FACTS are, from observing parity in other states, that parity for MH benefits increases premiums 0.3-0.7%, and parity for AODA benefits raises premiums even less, only 0.1-0.2%. We can expect that Senate Bill 375 would raise health insurance costs 0.4-0.9%. I have included with my testimony a copy from an article by Milliman confirming this fact—and you know that Milliman is one of the best sources of consulting advice to businesses large and small.

Let's do what's right for Wisconsin employees and EMPLOYERS. Let's level the playing field for all businesses and health plans, set the standard for coverage uniformly across the marketplace, and pass this AFFORDABLE legislation which will return more addiction and psychiatric care to the private sector and lower the burden on state and county governments for providing this necessary medical care.